ADVISORY COMMITTEE ON MANAGED HEALTH CARE
MEETING SUMMARY
April 11, 2001

MEMBERS PRESENT: Senator Art Torres; Susan Urbanski; Larry Levitt; Michele Melden; Dr. Pratibha Patel; Diane Griffiths; Steven Thompson; Thomas Porter; Dr. Rosetta Hassan; Dr. Steven Bull; Naomi Strom; Dr. Morton Field; Tom Davies; Jose Gonzalez

MEMBERS ABSENT: Jay Gellert; Dr. John Alksne; Dr. Alfred Forrest; Irene Ibarra; Elizabeth Imholz; Dr. Stuart Needleman; Paul Kumar

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AGENDA ITEM I: WELCOME AND DISCUSSION OF ADVISORY COMMITTEE ACTIVITIES

MR. ZINGALE, Committee Chairperson, and Director Department of Managed Health Care, welcomed committee members and the audience to the meeting, asked members to introduce themselves, and introduced Herb K. Schultz, Deputy Director for External Affairs.

MR. SCHULTZ, Deputy Director for External Affairs, discussed a handout summarizing the January 22nd advisory committee meeting, and asked for comments, changes or corrections to it. (There were none.) He discussed a handout of proposed advisory committee products and a proposed time line for the remainder of the year, and stated that the full committee will be brought into discussions of the work being done by subcommittees, and will ensure all work products of subcommittees are completed and approved by the full committee in accordance with statutory requirements. One legislative mandate is to produce an annual report – a draft's anticipated to be brought to the full committee July 10th. He suggested that the full committee discuss, review, and consider adopting the prevention report at the October 10th meeting and at that meeting it also review the status of the AB 78 regulatory framework study looking at the potential for consolidating some services from the California Department of Insurance into the Department of Managed Health Care. The uniform quality audit recommendations, SB 2136, will be discussed at the December meeting, and a draft should be completed by the October meeting. The proposed standards need to be promulgated by the department no later than January 1, 2002. Other agenda items for future meetings might include reviewing comment letters on proposed regulations and other things that the committee is mandated to review at its discretion.

He asked for comments from members (there were none), and stated there seems to be consensus about the proposed schedule. He anticipates having comments for the committee to review about the grievance independent medical review regulation at a later date. The most recent schedule for meetings of the full committee to be held for the rest of the year are as follows: July 10th in Los Angeles – changed to San Francisco, October 10th in Sacramento, December 5th in Los Angeles. Those for subcommittees include: Quality and Performance Measurement May 15th in Los Angeles, and July 25th in Sacramento, and September 12th in Los Angeles; Regulatory Implementation and Structure May 9th in Sacramento, June 28th changed to July 18th in Los Angeles, August 16th in Sacramento, and September 25th in Los Angeles; Health Care Education and Access May 1st in Fresno, June 13th in Oakland, August 1st (cancelled) and September 6th in Los Angeles.

AGENDA ITEM II: QUALITY AND PERFORMANCE MEASUREMENT SUB-COMMITTEE

MR. DAVIES, Chairperson, Quality and Performance Measurement Subcommittee: Thanked sub-committee members Michele Melden, Senator Art Torres, Dr. Morton Field, Dr. Steve Bull, and Paul Kumar. The subcommittee has three major charges driven by legislative mandates: (1) the one-year Report Card; (2) the year-two Report Card which has occupied the bulk of the committee's attention to date; and (3) the uniform medical quality audit. We're pleased to report that we've initiated our examinations and efforts in that area and have identified a work plan to move us toward the completion dates necessary to meet the requirements of the legislation.

MR. SCHULTZ: Acknowledged the work of staff who have worked on the year-one Report Card – Andy Meyers, Tom Gilevich, and Diane McCarthy. A contract was awarded to the Pacific Business Group on Health to work with the Department and Patient Advocate to develop and disseminate both on the web and in print copies of the year-one Report Card. Pacific Business Group on Health President/CEO, Peter Lee and Project Director, Ted von Glahn, will discuss the project further.

MR. LEE: Some years ago Consumers Union coauthored a report looking at some of the Department of Corporations' short fallings, one of which was the relative invisibility of the department. I think this Report Card initiative is an incredibly important one to address in relation to the visibility of the Department of Managed Health Care. These Report Cards are about building on something that has happened in the last ten years in health care, which is a whole new age of accountability, part of that is having information in all the stakeholders' hands. The department has an opportunity to provide direction and frame how the entire market talks about health plan performance and quality, and to help build a common language.

I think the Report Card will help consumers make better decisions, encourage public accountability and help improve performance of health plans. Report Cards are a carrot approach to boost quality performance. They are about rewarding plans that do better and raise the "performance bar." He referred to handouts showing results from a study by Kaiser Family Foundation and the Agency for Health Research and Quality about consumers' use of quality information. He said that it shows a large room for getting more information out in consumers' hands, and he sees a huge opportunity for the department to get information where there is a gap.

Consumers are already saying they are ready for information. The Report Card will not be the end all for consumers. They will continue to go to consumer groups, or plans or doctors. If the Report Card isn't valid to doctors, then it's going to be undercut. We need to recognize the whole range of other stakeholders that get this information out there.

We believe that the Pacific Business Group on Health can do this project because: for over ten years it has served as an independent source of information for consumers, employees of its member companies, which reflect over three and a half million Californians; health scope one of its projects for years, has produced credible, scientific information; it is a nonprofit group made up of both large employers including CALPERS, Chevron, and Wells Fargo; and it operates PacAdvantage, which used to be known as the Health Business, a purchasing tool for small businesses. It has piloted very early health plan consumer experience surveys for a long time; has established relationships working with health plans, consumers, through our member companies and doing surveys on their members on what works, what doesn't; and has worked with plans through

the California Cooperative Health Care Reporting Initiative, which works as a platform, under what was a very fast time frame framed by the legislature for the department that enables Pacific Business Group on Health to help the department hit the ground running.

MR. VON GLAHN, Pacific Business Group on Health, Director of Consumer Information and Activation: We see California consumers as primary users, not the sole user of the information. We want all the folks who have a stake in health care quality in the state to use the information, but the focus is on the consumer at the point of action of choosing a health plan, making a health care decision.

Our scope in year-one is to include commercial HMOs, specifically HMOs working with the California Cooperative Health Care Reporting Initiative mechanism, for data collection. Deliverables will be a website and a print report, establishing a platform for year-two and beyond – including the electronic website, the platform, the process for gathering the raw data and moving it into the site, and the method for how information is stored and displayed, and communicated to consumers. Fifteen HMOs (12 companies) participate the California Cooperative Health Care Reporting Initiative, accounting for the lion's share of the commercial activity in the State of California, and will be included in the year-one Report Card. Quality measures will cover what is self-reported by consumers, information pulled by the medical chart or information gathered by the claim or in account records. The summation is the print version and the website. The time line will be available this fall.

Quality data that we'll be using for the year-one Report Card include The Consumer Assessments of Health Plans Study data, consumer self-report of their experience of care and satisfaction with the health plan services and the providers within that health plan. Added to that will be The Health Plan Employer Data Information Set measures, obtained from administrative records for a claim or account record or a medical chart. Through those two primary sources we provide the process of care information. In addition, we'll include the department's complaint data.

We are trying not just to provide a static snapshot of performance, but address how to engage consumers to use the information. A very important part of the work is around the messaging, what is it, how to reach individual consumers so that they want to grab this information and use it–a big challenge, as the science is fairly immature.

The Health Plan Employer Data Information Set and The Consumer Assessments Of Health Plans Study measures might have individual measures across health plans, so we'll give consumers all of those. We don't expect a lot of people to use them, but some will. More importantly, for those who won't use them will provide aggregate performance measurements in digestible, concise, relevant set of summary indicators. We know enough about the science of individual decision-making shows that no one can process more than ½ dozen elements at any one time in making decisions. So, should we wish to drill down and find the detail, we'll be able to do that.

Another aspect of the deliverable is helping people winnow their choices, whether that is as simple as geographic winnowing things down to an individual's area of residence or of being a parent with children, the performance information will speak to those and other needs, such as persons who are ill and continually needing services.

The printed Report Card will have essentially four different versions for four geographic regions in the state, both in English and Spanish–the primary website will be in English and some sections will be in Spanish.

Finally, another aspect of this is a stakeholders report for the Advisory Committee members, legislators and other interested constituencies around the state that will speak to the notion of the emergent science, intended to help in year-two and beyond, including some lessons we will have learned.

We have an opportunity to be mindful of the cost of quality information, data collection, and using some existing mechanisms in the state today, communicate to state consumers, and to test and advance the state-of-the-art in this area. Some nice work done in other locales around the country will help us and we'll have a chance to validate this work with consumers early on.

MS. STROM: How might we better integrate prevention into the process we are discussing?

SENATOR TORRES: The census data confronts us with the Asian American and Pacific Island communities throughout the state. Was there any thought given to what languages in addition to Spanish would be available, such as Mandarin or Cantonese?

MR. VON GLAHN: The department expressed a very strong interest in having multiple languages over time, one struggle is translating some of this technical information can be very expensive.

SENATOR TORRES: There are several federal court certified interpreters in Los Angeles and San Francisco for the translation. If we're going to make a Report Card for the average person, I hope we don't have a technical vocabulary so it wouldn't make sense or be valid to the average person.

MR. SCHULTZ: The Pacific Business Group on Health is looking at the technical development of the Report Card. The Department can and will examine other resources where pieces, whole or in part, can be interpreted or done into different languages, and we will look at that. Regarding year-two's Report Card, we have been factoring all those discussions in and the languages mentioned have been central to that.

MR. DAVIES: I think we're really talking about the difference between content and presentation in effect. Going forward we can talk further about it when we get into those considerations, because it also expands the scope and coverage and a number of other considerations.

MR. LEE: Pacific Business Group on Health gives an award to health plans and medical groups. Historically, the organization has looked at quality data use and electronic sort of exchange, which advances the industry, at partnering and collaborating and at cost effectiveness. We are not carrying across the blue ribbon process to the Department of Managed Health Care report.

MR. THOMPSON: In addition to the consumer ranking? (MR. LEE: Yes.) I understand you're proceeding with commercial plans only in year-one. It seems to me that this process is more serving of ranking commercial health plans where there have been other products available to serve the consumer, what are the plans to include those health plans?

MR. SCHULTZ: That is a decision and discussion that the advisory committee is to advise on for year-two. The department staff has had internal discussions and subcommittees have been conducted about the incorporation of Medi-Cal, Healthy Families and Medicare. Existing legislation builds off of existing public and private sector efforts. We have spent a significant time talking with officials at Department Of Health Services, and have begun talking to folks at Managed Risk Medical Insurance Board and other agencies about that. It's a matter of dealing with statutorily the first year and what those time frames are and what's presently available. There have been some real issues raised about where the state measurement is on the plans and what will be available year-two versus year-one.

MR. THOMPSON: Is that anticipated endeavor to be part of the year-two evaluation?

MR. SCHULTZ: We have gotten strong indication from stakeholders that that is the desire and so we're talking about that.

MR. THOMPSON: Healthy Families is doing its own ratings right now and there is some controversy as to how they are going to do the final rankings and so forth. But I'm concerned that the less sophisticated consumer, the poor of California, is the last to have something that might assist them in selecting a health plan. I think that it's an important public policy perspective that should be included in this contract as it goes to finalization.

MR. SCHULTZ: Again, their contract is year-one, not year-two. So I think you are talking in terms of front burner for year-two.

MR. THOMPSON: I'd like to include it in year-one, but I assume that the train has already left the station. Including those rankings in year-one, I think would be great; if that's impossible given the time frames and so forth that are going on, I really think it important it be included in year-two.

MR. ZINGALE: Half of consumers have a choice, right? Were Medi-Cal and Healthy Family enrollees considered in that percent? I assume those populations all have a choice, right?

MR. LEE: I'm not sure. In the first year, we can communicate with Healthy Families, and the Department of Health Services about our methodology, about how to collect this information, because we want to ensure consistency of communication that it would not serve anyone to have Department of Health Services, Healthy Families, and Department of Managed Health Care have different measures out there. So, in our contract charge is commercial enrollees, but conceptually part of our charge is to help the department work with its partners to have consistent messaging out there in general.

MR. SCHULTZ: We've had extensive discussions with Department of Health Services given the work that the subcommittee has been doing, looking at that population, trying to understand from Department of Health Services where their own process is, where Healthy Families is, and talking with Managed Risk Medical Insurance Board. I think we're all speaking the same language and were trying to partner with them and understand what they may or may not be doing.

MR. THOMPSON: I would hope that since they are all plans licensed by your department, if they choose not to go ahead that wouldn't deter you, that's my sense. (MR. ZINGALE: Yes.)

DR. PATEL: For your report that is coming out, what is the period of data collection?

MR. VON GLAHN: We have three primary data sources, and the durations vary. For the consumer experience with the health plan, those are surveys that are administered actually during the current time period. For the medical chart and claims administrative records, they're being pulled over the calendar year of 2000. And the complaint data from the Department will most likely be from the most current period, such as the 1st quarter of the year – It's not finalized, but it will probably be from the first quarter or perhaps even later of the calendar year.

DR. PATEL: One of the committee measures that you mentioned was a performance of health plans, how they manage critically ill. How do you link that so the consumer can understand that that has a cost consequence?

MR. VON GLAHN: We don't in year-one. The issue is better addressed in the year-two discussions. So, we really are focused on quality performance in year-one. But again, there are other attributes of making a choice, whether it's cost, convenience to physicians and others, but that's not within our scope in year-one.

DR. PATEL: That's for the second year because it is very important, otherwise there is going to be adverse selections by patients, clinically ill patients, who will be moving to the plans that perform well, but not be willing to pay the cost because they don't see the connection.

MR. ZINGALE: Broaden the discussion to year-two issues, if that is all right with other members.

MR. DAVIES: The report and presentation made by Dr. Hibbard from the University of Oregon was extremely helpful. I recommend to the director at a future meeting it might be very helpful to have Dr. Hibbard return to meet with the whole committee. The issues that we dealt with are well summarized in our notes from that meeting; the key one was whether Report Cards should have a statewide perspective or a regional perspective. We concluded that regional was most important, but not to the exclusion of a statewide picture of performance of the plan as a whole.

We looked into including physicians and physician groups, considered obvious difficulties and limitations of existing data systems to include the actual care providers in the Report Card in some fashion. We discussed that the year-one Report Card will deal with existing commercial plans and the vast majority of most folks covered by HMOs in the state, and how and in which ways to include Medi-Cal plans and whether there were different kinds of reporting issues that should be considered than in the commercial arena. We did not reach a conclusion on that. Similarly we've talked about what to do with Medicare plans. Dr. Bull, a member of our committee, thought that the specialty plans probably ought to be included in some kind of performance mechanism during the year-two period beyond the legislative mandates. We had a good deal of discussion about the whole notion of the adequacy of The Health Plan Employer Data Information Set and how it might be used as a measuring system. And that led us, again, to the consumer needs, both in terms of how to present the data especially in light of the question of cultural sensitivity and linguistic concerns.

MS. MELDEN: I was interested in whether the consumer surveys were culturally and linguistically appropriate, and focus testing for different groups. We want to look at the growing population of Asians and Spanish speakers, and others. Also, we may need to choose different kinds of formats for different audiences depending on the cultural and linguistic sensitivity and the socioeconomic

status of the people using them. I was hoping there might be some middle ground where those plans and those provider groups that don't quite come up in terms of their grades be worked with at the department level so that they can be brought up to speed.

I also request that we get some expert advices to pick out several measures to make sure that we look at health promotion especially to low income persons. Last, the Report Card should provide information to people who have chronic illnesses and disabilities, both adults and the parents of children with those health issues.

MR. DAVIES: That's why we felt that we needed local focus to help people make selections and to develop a statewide picture, that might help regulators and others who want to get a general picture of how plans are performing and purchasing and purchasing on a national basis.

MR. LEVITT: In considering year-one and year-two, are there plans to aggregate the information or is it going to be a string of scores on a whole bunch of measures? There are controversial issues about aggregating it, and how you weigh different types of measures. Does the department have plans for requiring plans to submit information or using the department's licensure or enforcement capacity to make sure the data is accurate and in fact reported so it can feed into the Report Card? Finally, has the subcommittee talked about including PPO-type plans in the Report Card?

MR. DAVIES: We have not really addressed, the last question, and it certainly is appropriate as is discussing the importance of the underlying information.

MR. LEVITT: What is the plan for year-one in terms of aggregating and non-aggregating?

MR. VON GLAHN: We will aggregate the information, and we'll come back to the department and the Patient Advocate with a couple of scenarios, which indicate which data we weighted and which we left un-weighted. We'll have a couple of options for folks to view as we go along.

MR. LEVITT: You're talking about aggregating into the categories but not a single (MR. VON GLAHN: No, thank you for that clarification. One of the categories might be staying healthy or chronically ill and illness that is the intent, a subset of categories.)

MR. LEVITT: Even aggregating a handful of measures most consumers will have great difficulty sorting them out. It's incumbent on us to do some hard work behind the scenes and give consumers very aggregate measures that are going to be helpful, even potentially, to an overall score on plans based on our expertise and we're giving this plan a higher overall score than this plan.

MR. DAVIES: We thought the regional approach was the important approach for consumer communication and use -- it could not be an either/or scenario. There wasn't a remaining important approach to be able to aggregate the performance on a statewide basis or on the whole service area because some of the plans don't operate on a statewide basis. The question now is what are the regions and how to break it down in the most meaningful way. The department has to determine this.

MR. ZINGALE: A Kaiser Family Foundation survey showed things like having the choice of doctors, breadth of coverage, distance you'd have to travel, waiting time for appointments. Cost was relatively low on consumers' lists, but high on the employers' lists. Is there other data out there that

contradict or reinforce what we know about what consumers want to know? How can it be meaningful to give consumers information about a plan's outcome when we know it's probably their own experience that is going to be particular to their medical group, which may vary widely in a plan that gets high scores or a plan that gets low scores.

MR. DAVIES: That's why we're exploring the idea of getting reporting on physician group/doctor levels at some future point. To some extent, what the consumers want is always based on what they already know about. A lot of our investigation and discussion has centered on that kind of question. In the final analysis, I imagine that our second-year card is going to be followed by a third and a fourth, which will be further improved as we're able to judge the usability and reaction to and impact of our successive efforts.

MR. GONZALEZ: Are consumers informed enough to understand what they are being told and is that a value to them? Example: Where there is a standard among the HMOs, access is defined as how soon can you get an appointment and when you get to the doctor's office, how soon will the doctor see you. All doctors in the Latino community don't do appointments - patients don't call up and make appointments because they have been used to going to the clinics, being the first one, taking a number and waiting. That is something that has gone on culturally for years and years. My concern is about standards of quality that the consumers may not be there yet in terms of what they consider valuable. If we're going to make this Report Card work for the entire population, it is not enough to just translate it, we've got to understand the different cultural values of the different communities. As we assess the priority of their care, we are assessing them according to their values, not according to our values.

MS. IMHOLZ: What do consumers want or say they want, and what moves them to make a choice and what actually makes them make a choice? Preventative measures are really important for a lot of reasons, but research shows in many cases it doesn't move consumer choice; they think it's a matter of individual initiative as well as policy within the plan. I'm wondering if you have a sense of putting in preventative measures—and what those handful of quality indicators are, that we might be focusing on?

MR. LEE: We're looking at the fact that all consumers are not alike, and which consumers are more apt to use a Report Card, for example, those who are chronically ill. What we see in surveys indicates that consumers respond to what they already have seen, and there hasn't been a lot of outcome quality information. They say they'd like the information about outcomes relevant to them yet they haven't seen it very much. What we're going to try to do in the first year is develop a tool that can be responsive depending on where consumers are coming from, for example, if someone is chronically ill or has children that are…consumers want to know what other consumer's experiences have been. The Consumer Assessments of Health Plans Study is a very good instrument that asks, are you happy, have you had an experience that you haven't gotten care you and your doctor needed.

MS. IMHOLZ: What do you think the Kaiser studies have shown the consumer to the extent they take care of quality measures at all? They are drawn to and provided with physician-level recording, so I would encourage that down the road.

MR. LEE: It is a challenge for the department to look at the bigger difference between medical groups than between health plans, and a wider spread between the medical groups in California than

between the aggregated experience of people in plans, and that is clearly not what we're trying to address in the first year.

MR. THOMPSON: For people that don't have plan choice, that distinction is critical because the only choice they have was in the single plan in the provider system. When you don't rate physician groups, you're leaving out many persons currently covered through health care.

MR. ZINGALE: Are there factors that transcend the differences toward medical groups; can we gravitate toward those?

MR. LEE: I don't want to say health plans are not a relevant part. The department's role is to hold them accountable for that. Are there pieces that transcend: I don't have a quick answer on that.

MR. SCHULTZ: Moving toward physician-group reporting is even more important in California, as Californians are more likely to be on an HMO. HMOs might have less importance for their care because of prevalence of Catholic medical groups, delegate medical groups and certainly the surveys bear that out. People look to the physicians as much more determinant than quality of care of health plans.

MR. LEVITT: Experts sometimes force people to eat their spinach. So, maybe it's important to give them dessert as well, particularly to get consumers to pay attention to the Report Card if all we provide them are sophisticated quality measures that are hard to get them to understand, it may be hard to get all but a small number of consumers to understand. Consumers might still find helpful in choosing a plan things like scope of coverage, breadth of the network, what is the waiting time to get an appointment. These things can vary tremendously from one plan to the next, and the surveys show those are things the consumer might look to.

MR. LEE: Another example is the department's complaints. There is a lot of discussion of how is that a good indicator of health plan quality. Consumers believe that complaint information is a key indicator.

MR. SCHULTZ: I just want to underscore the use of the role of complaint data as a statutory requirement to the department.

MS. MELDEN: I think we should work on getting information at the provider-group level. I don't want to get away from reporting on the plans and all those indicators, because I think it's important to keep pressure on the plans to work with solid provider groups, so they need to be seen hand in hand. There are resources available to educate consumers on how to use these targeting different groups. It would be necessary to reach out to community-based organizations so they can educate consumers on how to use these and they can take them up as advocacy points.

DR. PATEL: Is there any discussion among the subcommittee to include each plan's medical loss ratio, meaning the percentage of the premium they actually spend in individual health care, the administration cost and the profit, because I think consumers are very interested, and because the health plans are different.

MR. SCHULTZ: I think the goal is there should be reporting for all plans, it's a matter of how vis-a-vis Knox-Keene and what is currently available and what will be available.

DR. FIELD: I think we pretty much decided we are going to come up with a sliding-scale rating, so year to year consecutively rather than the percentage saying, you're in the top third, bottom third or middle third of the plans. We're deciding whether or not that will be applicable in the first year, but we're aiming to be able to do that in the second. One of the avenues of information for the consumer is the physician. If the Report Card is not relatively valid scientifically, it's going to be downplayed, like The Health Plan Employer Data Information Set data is now. Therefore, we're making an effort to include specific outcomes, which will be meaningful to physicians, whether or not they are meaningful to the consumer. We have decided to stratify the responses in consumer reporting of satisfaction based on the number of contacts with the health plan itself, which is a good way of isolating the people who have chronic complaints. Individuals with one contact or no contact with the plan during a year are going to have an entirely different perspective than someone who has had seven or eight contacts during the year.

PUBLIC COMMENT

MS. CAROLINE RIVAS from the Community Health Council, a policy and advocacy group based in Los Angeles working primarily on behalf of Medi-Cal consumers: (Passed copies of letter from Community Health Council supporting of the recommendations made by the subcommittee recognizing that commercial Medicare and Medi-Cal enrollees are key audiences and that the year-two Report Cards should include separate reporting for these populations.) Community Health Council requests that the process continue to obtain consumer input in each step, especially with regard to the development of a Report Card for Medi-Cal consumers. Each consumer audience is unique in its literacy ability, language barriers and understanding about health plans, therefore it is imperative that input from consumers and consumer advocates be included in the development process of a Medi-Cal Report Card. We suggest including the consideration of sub-work groups in the work of the Advisory Committee and its subcommittees, and expand on subcommittee membership to include broader community input of development of a Report Card specific to Medi-Cal consumers.

MS. BETH CAPELL of Health Access, a member of a collaborative that includes Center for Health Care, Consumers Union, Latino Issues Forum, California Network, and Western Center: It's important that the Report Card reflect whether plans make any effort to determine cultural and linguistic needs of their enrollees and the cultural and linguistic capacity of their provider network. This is something that expands beyond whether the Report Card itself is culturally and linguistically competent, which we support, but beyond that we think the Report Card should speak to whether there is a capacity to provide the care that is needed in the language of the people that are receiving the care. We ask that the department begin the process of encouraging plans to look at this issue by asking the whether cultural and linguistic needs of enrollees are evaluated and whether the cultural and linguistic capacity of provider networks is evaluated.

MR. ZINGALE: You have to ask the plans for it?

MS. CAPELL: That’s our best understanding with respect to Medicare. Those consumers with the most contact with plans have different experiences than other less frequent users. We’ve found that both seniors and persons with disabilities and others with serious and chronic illnesses are leading indicators of trouble in the health care system use it the most, and are the first to know when there is a problem. We strongly encourage separate reporting on Medicare for that reason. Regarding

aggregation of the indicators, since you're going to have web capacity, you may want to allow people who have a serious condition in the family to be able to drill down to a more detailed level, even if you have aggregated numbers that are more useful to most of us, including those of us who only glance over this and are blessed to not particularly need the health care system on a regular basis, but for those that do, have the capacity to get more detailed information. We agree with Director Zingale, wait times and access to the network are things consumers' care about the most. We're disappointed that we're not going to see that in year-one. We encourage that in the future report.

MR. ZINGALE: Peter, I assume some of that is going to talk about these things (MR. LEE: Absolutely).

MS. CAPELL: With respect to physician groups, we very much agree that we should move to reporting in the physician-group level and also including PPOs respecting that that's difficult to do in the first year. We ask Pacific Business Group on Health and the department to look at whether you can include information around whether the plan relies on a delegated model that locks the consumer into a single medical group when they choose their first provider. It hasn't been field tested anywhere, it may present some problems, but it's an area that we think merits exploration. Consumers know that if they join Kaiser that they are locked into a specific set of providers. They don't know that if they are an enrollee in another health plan that they are locked in.

MR. THOMPSON: Some health plans do not do capitated delegated risk arrangements with physicians groups. How do we measure the provider involvement for those plans or those parts of plans that do not do group contracts or Independent Patients Association contracts?

MS. CAPELL: What I'm suggesting is in the first year you might ask the question whether the plan relies on a delegated model where you lock consumers in as just an intermediate step on this whole effort. Although Pacific Business Group on Health's methodology is public, this is the first arena in which consumers and other organizations get to participate and comment on their methods. So this is the first time we get to participate in that discussion, so we may be a little behind some of the other players.

MS. MELDEN: My understanding is that there was going to be an effort undertaken by the department to survey the plans and providers on cultural/linguistic competence?

MR. ZINGALE: Introduced Angela Mora, Patient Advocate in the Department.

MS. MORA: We sent a survey to all HMOs to get an idea of where they stand in terms of cultural and linguistic competence and we're in the process of gathering the results of the survey.

MS. MELDEN: Will you be reporting on that? (MS. MORA: Probably not in year-one.)

MS. MELDEN: I'd like to recommend that as part of year-two and beyond that that be captured in the reports.

MS. MORA: I know the needs and the gaps and sensitivity in terms of cultural and linguistic needs, and I want to make sure we approach the issue from every possible side, and that whatever we do in this area that we are cognizant of the fact of the gaps that we have in the medical field. One of the

reasons we're not using any of the data probably is we're not sure yet if it's going to be very useful. We want to have a vision, a plan for addressing whatever gaps and whatever needs there are, so we can serve as support for the plans, the medical groups, in terms of developing or beginning to develop a system that is going to be long-lasting and that is going to eliminate those gaps.

MS. STROM: The Health Care Education Access Subcommittee is working with the Patient Advocate and in developing that plan we're looking for an opportunity to outsource those resources through our institutions in California, to look at what is currently being done, look at the linguistic differences and cultural differences as well. There is some effort already in the process that will be part of our report, perhaps we can look at expediting that as well.

MR. GONZALEZ: Has there been any discussion with regard to allowing or developing a mechanism for health plans to capture that information when the member fills out an application? One of the difficulties we're going to have is health plans are going to say, yeah, we do it, but nobody knows what percentage of their enrollment has language problems, or cultural differences.

MR. SCHULTZ: The department is beginning effort in this area. What the survey is designed to do is give the department a baseline for what the plans are already doing. We have our own regulatory authority of what we may ultimately be able to require. We spent a significant amount of time talking with Department of Health Services, with Managed Risk Medical Insurance Board, and other stakeholders about their standards for cultural linguistic competency, and what the department needs to do, so it's very much the beginning of that. The question here has to be what's right and we have to see the initial responses and move from that.

MR. ZINGALE: The Patient Advocate tells me this initial inquiry sent to the plans asked what they do to collect cultural demographics.

MR. LEE: A couple of Pacific Business Group on Health activities this year working with Health Net, Kaiser, Blue Cross and -- forgetting one other plan-- we're doing a physician-group level consumer experience survey of the largest medical groups in the state. Those are the ones that said we are ready and willing to be assessed and compared medical group to medical group. They recognize it is important so that this information will be available this year. In addition, we're working with, I believe, eight PPOs to field a PPO-level The Consumer Assessments Of Health Plans Study this year that will be applicable. Pacific Business Group on Health shares belief that we need to get these standards both down to the medical group level and out to delivery systems.

MR. DAVIES: We discussed the issues of the uniform medical audit at our last meeting. Having an opportunity to set out a time line, a work plan, of what things we're going to do and what time to start to scope out the notion of what we think the nature of this audit is, a very general sort of conversation as a part of our last meeting which was still focused primarily on the second-year Report Card. It's all reported quite fully in the notes of that earlier meeting and our intention is to move on in a stepwise manner, so that in our next meeting we'll start to deal with more explicit issues and start to identify the issue and build as much of a consensus as we can with the idea that by our fall or winter meeting of the whole committee we will plan to report our recommendation. The committee then will be expected to take some action to make a report to the department. I presume that everyone is somewhat familiar with the requirement, and if you're not, we will brief you as we have more information to tell you about it at our next meeting. Are there any questions?

PUBLIC COMMENT: NONE

AGENDA ITEM III: REGULATORY IMPLEMENTATION AND STRUCTURE SUBCOMMITTEE

MR. LEVITT: (Referred to draft letter handed out that summarized the last subcommittee meeting.) At the last subcommittee meeting, we introduced the topic of the fiscal solvency, had a presentation from staff summarizing the status of the regulations; we then had an abbreviated discussion of the regulations.

MS.HIGA, Department of Managed Health Care, Deputy Director for Plan and Provider Relations: The regulations were adopted by the Office of Administrative Law as the emergency regulations. Simultaneously, that same package of regulations also began formal rule-making process -- we're now in the middle of a comment period, so discussion at the subcommittee meeting last week, and any discussion today would be for the purpose of having committee members provide comment that could be incorporated into a public comment letter that the advisory committee would submit to the rule-making package. In addition, individual members of the committee could also submit their own individual comment letters to the rule-making package if they chose to.

MR. THOMPSON: I support these two recommendations, but the statute requires that the director provide a "rating" system, for risk-bearing organizations. While that would not disclose, in my view, the financial information covered here, that distinction, I think, should at least be noted if we're going to pass these recommendations on. The statute requires the director provide a rating of these organizations, and so that rating could not be covered by these recommendations. I wanted to just make clear that this was detailed information and nothing would be contrary to those responsibilities contained in the statute. I think it's not very clear.

MR. GONZALEZ: What value do you see to the public and what would be in those financial statements? Without their really understanding the organization, what value would there be from the standpoint of making any choices?

MR. ZINGALE: This clearly merits a longer discussion at the next financial solvency standards board meeting. I put the same question to consumer groups in a previous financial solvency board meeting, and I think to generally summarize, what is at value to consumers is anything that can provide a red flag for them or a situation like we got into with KPC, where a medical group goes under and the transition becomes at best one of anxiety and uncertainty for consumers. The challenge, to the board and the public who testify at that next committee hearing, is how to address that in some meaningful way without disclosing a lot of information that isn't useful to consumers, and without putting medical groups at a competitive disadvantage with their peers or with the HMOs that they negotiated contracts with. The statute, as you may know, is general on this. I'm going to need a lot of guidance from folks on that board.

MR. GONZALEZ: I thought one of the things that we were trying to do with the criteria that was recommended was to give you an ability to look at and say, we believe this group is in some kind of jeopardy, let's focus on it and let's try to do a corrective action plan. I think the director would have some level of responsibility to communicate to the consumers, if you went to a plan, the flag went up and somebody said, there is a solvency issue, we need to advise the consumers that this problem exists. I don't agree that what happened with KPC is that the consumers had no warning, and all of a

sudden, you're being transferred and they never really were given sufficient notice to be able to make whatever choices they might want to make. My concern is that we go the other extreme and say let's put everything on the table all the time and people are reacting to it without really understanding what's going on.

MS. STROM: What alternative compromises have been discussed in your group?

MR. LEVITT: It wasn't an issue that we thought we should take up in any detail. We are proposing that we allow individual members of the subcommittee or the committee to submit comments, but that the committee as a whole won't have a full discussion. (DR. PATEL: Agreed). I'm not sensing any opposition to this approach. Next, we have been fact finding around the current regulatory responsibilities approach to the California Department of Insurance and the Department of Managed Health Care and the plans for the regulatory study.

MS. IMHOLZ: How do the Department of Insurance and the Department of Managed Health Care's complaints come in, and how do they get handled in both the Departments? A presentation by Shelly Rouillard, Health Care Hot Line, explained how one private nonprofit complaint resolution organization handles their complaints. The Department of Managed Care made a presentation with some detail about the numbers of complaints that they are receiving, a huge jump from what the Department of Corporations had received, a tracking system being upgraded; detail about independent medical review, how many complaints have come in, and how many have been dealt with and what the results have been. Department of Insurance explained how they handle consumer complaints on the health side. Unfortunately, it's a little hard to get exact numbers about the complaints that they receive and how they are handled, but anecdotally, they tell us the top reason for the complaints is claim denial and claim handling. Their tracking system doesn't seem to be comprehensive at this stage, they follow the Health National Insurance Commission guidelines and categories. And their remedies were for out-of-plan compliance, they can be sent to compliance, but they told us that they rarely are. They acknowledged also there is some confusion on the part of plans and sometimes staff about the jurisdiction between the Department of Managed Care and the Department of Insurance and which rules should apply on a particular plan that might have both PPO and HMO features to it. A second panel, on the regulatory oversight at which the Department of Managed Care talked about medical surveys done by statute every three years. Relatively broad surveys, quality of care and many issues about their market conduct studies done every three to five years, selectively based on high rates of complaints or legal department leads that they might have about wrongdoing going on out there.

MR. THOMPSON: We needed to know the statutory basis of the insurance commissioner's jurisdiction over health plans since it was created by statutory initiative. I think our recommendation was to seek legal Council from the Attorney General and I think that that's absolutely critical before we proceed. (MS. HIGA: Department of Managed Health Care legal staff are looking into that.)

MS. IMHOLZ: We identified other potential areas for exploration in the regulatory framework study: impact on consumer protection and complaint procedures, revenue impact on PPOs and HMOs, impact on administrative simplification, ability to improve health care quality, and implications to improve fiscal solvency protection on business operations and impact on providers.

MS. HIGA: We received input from the subcommittee members as well as members of the public for consultants, largely academic consultants, that the department might consider contracting with

in order to get some assistance on conducting this study. We've contacted several recommended consultants and are continuing to speak to them to evaluate their availability and well as their interest and qualifications to do the study. At the same time, we're also evaluating and defining what kind of background research can or should be done by the Department of Managed Health Care staff and working with the Department of Insurance to look at what kind of information we can produce for the subcommittee to consider as well as for the consultant to use as background for its work on the study. We'll be wrapping up discussions with some of the prospective consultants by the end of this week and then hopefully move forward on a more formal relationship over the next several weeks.

MS. IMHOLZ: There is an October deadline to bring the committee the report and bring it to the director.

MR. LEVITT: Representatives of the Department of Insurance and the Department of Managed Health Care and representatives from the industry and specific health plan groups were incredibly forthcoming and helpful at our last two meetings and will accelerate our fact finding pace.

MS. HIGA: Since the last full committee meeting we had a discussion with leadership of the Department of Insurance and they asked that we always keep them apprised about any discussion of the regulatory study that happens at upcoming full committee or subcommittee meetings and are asking that to the extent possible, they have appropriate data of the Department of Insurance at all the subcommittee meetings so they can be available to provide technical assistance or answer questions that have come up from the subcommittee members.

DR. FIELD: Can we talk about the summary of complaints to the consumer hot line? Of those that were resolved in favor of the patients, the reason they were resolved was the plan was completely out of line. What is the incentive for a plan to learn and stop making the same kind of egregious mistakes over and over? There seem to be no penalties for them; they end up paying what they should have paid in the first place.

MR. ZINGALE: The complaint process gives us an aggregate picture of patterns or practices that may be referred to the enforcement division for action. This may not be a perfect example, because most of the information about late, nonpayment comes to us from the provider hot line. A rather high-profile enforcement action with PacifiCare involved the biggest fine California has ever imposed, probably any state or country has imposed. It led to a crisis of stock for PacifiCare. The Wall Street Journal and others said our regulatory action had facilitated that crisis in the company. So, if that isn't incentive enough to get your act together, whether there are reports coming to us of violations of the law by either consumers or providers, I don't know what would be. PacifiCare worked with us very productively to resolve late nonpayment quickly once we took that action rather than dragging it out. So this department is committed to what we call preventative regulation and solving as many of those problems as possible before any harm is done to consumers. That doesn't take away from our first responsibility, enforcing the law.

DR. FIELD: Is this the time or place to discuss some of the issues concerning the IMR program, which is also in here? A section that says that the provider or the patient's physician in essence, will provide copies of the medical records when requested, gives a time frame and so forth, but then it was recently passed in the Insurance Code, which says that the health providers have to pay for these records. Are these in conflict or what? Who pays for them, et cetera?

MR. THOMPSON: The distinction is that when the health plan requests an audit of a physician's office they will pay for the production costs of the records related to that audit. When the department is conducting an overall plan review, which could include records of a physician's office, I think that's the responsibility of the physician because nobody's thought about it yet. (MR. SCHULTZ: Concurred)

MS. STROM: How does that deal with patients' confidentiality in review of that process?

DR. FIELD: Now, the majority of requests to physicians are from plans that use the request for production as a significant delaying tactic. The records will be sent, you'll call back in days, they never received them even though you sent them, and the person that signed the receipt, it's illegible, that person no longer works there, and you send a second set. So my office is requesting payment before we send the records. I'm just wondering how it applied to this other area, which seemed to be entirely separate.

MR. THOMPSON: All health plan reviews, done by the department or by a managed care plan, must adhere to the same rules of privacy and confidentiality that would govern a physician, and if they utilize a patient record as part of those reviews, they are obligated by law in the same way a physician would be.

MR. SCHULTZ: We can provide a summary of what the new law (the Confidentiality Medical Information Act summary) is, and where I think Steve is going on this about exactly what we need to do in our process, and how it all applies.

MR. LEVITT: On the Independent Medical Review, the subcommittee had extensive discussion of the draft regulations, we're just awaiting the next draft of the regulations before we have any further discussion.

MR. SCHULTZ: The next draft of the regulations will be the formal proposed regulation that goes to the Office of Administrative Law, and that is when the formal process will start and when we consider that the committee would develop a formal comment letter to the file on that reg.

MR. LEVITT: In our discussion with the Department of Insurance it came out -- that the Independent Medical Review statute applies to plans -- to insurance plans regulated by the Department of Insurance as well, but the Department of Insurance does not plan to issue any regulations.

MS. IMHOLZ: They have had three cases. (MR. THOMPSON: Concurred)

MR. SCHULTZ: Acknowledged work of Diane McCarthy and Braulio Montesino, staff on the subcommittee, as well as Joy coordinating the subcommittee. And Ron Spingarn and Theresa Grace assisting us with the full committee.

PUBLIC COMMENT: NONE

AGENDA ITEM IV: HEALTH CARE EDUCATION AND ACCESS SUBCOMMITTEE

MS. STROM: Thanked subcommittee members: Dr. Hassan, Mr. Porter, Dr. Stuart Needleman, and Mr. Gellert. We're working on three components: (1) to develop a recommendation for improving preventative service; (2) a review of the department's health care initiative; and (3) the possibility of holding an E-Health Summit at our July meeting. We're developing recommendations that might serve as a guideline to the health care industry regarding improved preventative services. We have had a great deal of discussion relative to that; we are on schedule with regard to our efforts. We have had a tremendous amount of support from experts in the area within the field of preventative health care, particularly, Ms. Karen Bodenhorn, President and CEO of California Center for Health Improvement, who has provided a great deal of leadership in not only coordinating the presentations, but a lot of panel experts that have come before us to present their professional opinions, which have been instrumental in defining the landscape of preventative services. Our challenge is to relate all of the data and statistics that we are listening to and learning from, to actually drilling down to meeting the consumer needs and what does that actually mean overall.

The primary resources that we have been addressing, relative to prevention--is the Guide to Clinical Preventative Services--more of an evidence-based approach to preventative health care, and a population-based approach, the Community Guide to Preventative Services. Both have been instrumental in helping us to develop our plan of action. Pat Felton spoke to the entire committee about self-reporting by California consumers, where we are and what we are doing in the area of preventative health. Sara McMenamin, Director of Research for the Center of Health and Public Policy at the University of California, Berkeley talked about the state of health care and that although California HMOs cover many clinical preventative services, share of cost is a factor in terms of access and determination of those preventative services. Margaret Taylor, Director of San Mateo County Health Services Agency, talked about at-risk screening issues and managed care issues. Ashley Coffield, President of Partnership for Prevention, discussed the prioritization of preventative services, what is effectively working, and what is not. From a national level we heard from Jonathan Fielding, who discussed a systems approach to health care, changes in the health risk behavior, for example, as being an important factor in preventative health. Mr. Brad Myers discussed a little bit more in terms of the systems approach to such considerations as tobacco cessation programs, et cetera. We hope to be able to bring to the committee and to Mr. Zingale the very specifics that would be meaningful, particularly in the area of prevention. We hope to look at and also consider an integrated approach, prevention is not an isolated opportunity but an opportunity for us to include that within the educational initiative as well as the Report Card.

MR. SCHULTZ: Is your plan to dig down a level and begin to discuss recommendations that you would bring back to the full committee on how to further access preventative services, focus on preventative regulation in California?

MS. STROM: Absolutely, May 1st we hope to be able to have a specific outline of some preventative services that we might recommend to the committee. On a state and national perspective we have invited many of the HMO plan providers to speak to us on what is currently being done in preventative health care, what more could be done cost effectively so it's not just a cost-shifting opportunity on that of the consumers. So we're looking at alternatives. We're looking for a plan in terms of recommendation to the director that provides some real doable preventative health measures that we can take, something that we can really get moving, that we can use as a launch point for better preventative health in HMOs.

DR. HASSAN: Dr. Fielding, talking about the US Preventative Service Task Force, gave a very extensive list of different clinical preventative services, so trying to focus and narrow that down would be our major task. He divided the report into two criteria. One, clinically preventable burden which measures the burden of a disease a service can really prevent, which includes both mortality and morbidity combined, which he called combined quality-adjusted life years. The second criteria was the cost effectiveness that they used to try to identify services—what was really the net cost, and the cost of prevention minus cost averted. He recommended strategies. Two things that stood out were that patient recall was very important, plus patient education combined with other efforts was highly effective, but alone was not effective.

MR. ZINGALE: An idea included in your report from U.C. Berkeley is that recently the percentage of HMOs offering substance abuse prevention and sexually transmitted disease prevention and childhood injury prevention, HIV/AIDS prevention, prenatal nutrition, have all declined. Is that consistent with what other people know about trends? And have we asked representatives of the plans to explain why this is happening so that maybe we can provide incentives to reverse a trend like that?

MS. STROM: We hope to be able to do that at our May 1st meeting. Perhaps that's one of the areas that they haven't been measuring, it doesn't mean it's not important to consider, so we need to look at those issues more specifically.

MR. GONZALEZ: Is what you're saying that it does or does not include different HMO products like Medi-Cal and Medicare? Is there that distinction?

MR. STEVEN FISHER: My understanding was that there wasn't, that it didn't include Medi-Cal. It's overall across their product range. There are very strict standards of what we have to do as Medi-Cal and Healthy Families providers relative to prevention that don't exist at all in the commercial area. That's one of the things that you might want to look at because why duplicate something that has already been happening in a different department with a different managed care product, which is, very aggressive. There is a lot of that being collected, a lot of programs are required to put in place because of the population and the data Department of Health Services already has. Dr. David Bautista, UCLA, has tremendous data on the Latino population both in the different product lines and the different age groups that would be very helpful. And recommendations of what preventative programs would be successful.

DR. PATEL: Will your committee be looking at recommending some kind of a reminder recall system for some of these preventative services?

DR. HASSAN: Yes, and they gave several suggestions of things we can do -- in terms of tagging charts and color coding in certain ways so that they would know when to send out reminders to the patients.

DR. FIELD: This list from the Journal of Preventative Medicine seems to duplicate a lot of things that we hope eventually end up one way or another in the Report Card; does this mean there is going to be a duplication of effort?

MS. STROM: We're looking for the opportunity to integrate. There is some overlap, but we're also within our committee terms to look at some very specific parameters of measurement and which are

effective and which are not effective, rather than trying to reinvent the wheel. This entire advisory committee presents us with an opportunity to coordinate and integrate, again, what we're doing collectively.

DR. FIELD: If our committee does some of these things and brings you in on them, we're not going to be stepping on toes? (MS. STROM: Absolutely not.)

MR: GONZALEZ: Consumers have a responsibility too in terms of understanding what they are getting into. My concern about the way we're sort of structuring a lot of this is it's sort of like we're teaching consumers how to complain. What are we doing when that employer chooses that health plan and that health plan does a presentation they are required to do, and the employees are supposed to listen during company time to understand the benefits and they walk away and they take the packet and stick it in a drawer and don't look at it until something happens and then there is a crisis? If there was some way of better educating consumers at the time in which they enter the system, not once they are in the system and trying to use the services.

MR. ZINGALE: I wholeheartedly agree with that and I hope you'll find everything we produce will be relative to your HMO rights and responsibilities, a brochure the Department published on that topic. It says, "You have a responsibility to yourself and your loved ones to make healthy lifestyle choices and exercise your preventative care rights, discuss health risk factors with your doctor." As a long-time patient advocate, I think the first responsibility is really with each of us to protect our own health and the health of our loved ones. So I hope everything we do will reinforce that.

MS. IMHOLZ: Relative to the goals of letting consumers know about the department services and about the preventative care, have you thought about plugging in with or recommending that the department somehow plug in with all the efforts that are going on, outreach and enrollment for the Healthy Families and Medi-Cal plans.

MR. THOMPSON: With something like Healthy Families, enrollment has been significant, but the disenrollment is just as high as the enrollment. So in terms of reaching out and getting low-income folks to participate, we have got to find the answer to the question of why are you disenrolling. Some people have moved from basically clinic situations to having a physician available, finding out that access is not increased and going back to the more familiar clinic settings.

MR. GONZALEZ: If we do partner up with new efforts in Healthy Families to reach out to the low-income workers, we're going to be working with employers on the Healthy Families side and if we can tie that in, we're going to have people that are going to be in a commercial product as employees and because they cannot afford it, the spouse is going to be in Healthy Families and so are the kids. So it's a great collective effort in that particular population, working together with the plans that are doing that from a commercial standpoint.

MS. STROM: The brochures about your HMO rights and responsibilities handed out have been distributed to doctors' offices, legislative offices, pharmaceuticals who are supporting the cost of publication, if I'm not mistaken, and are being reproduced in multiple languages for multiple linguistic needs. (MS. MORA: We're doing Chinese, Spanish and English.)

MS. STROM: The Office of Patient Advocate has a budget of two million dollars for the educational campaign. We're looking at specifically where these needs are and best how to address it, under Ms. Mora's leadership.

MR. FISHER: We will also have posters, web pages, that kind of thing. We really want to get the graphic ads sort of modeled after the New York City taxicab ads. (MR. SCHULTZ: Initially, we're distributing them through legislative offices in the district and offices in the capital as well through briefings/meetings with legislative staff.) The Deputy Director of External Affairs gets a lot of calls from the legislative offices, a primary receiving point for HMO complaints. Legislative offices are a good place to distribute brochures and posters, so are human resource departments in corporations and other state offices, to reach people who are having problems with their HMO, so we're starting with other state departments, Human Resource offices.

MS. STROM: We're hoping to be able to bring to you an opportunity to look at what is being done within E-health, what's working, what's not working, where are the holes. Perhaps looking at the opportunity for the department to set standards and protocol taking into consideration patient confidentiality and perhaps moving the managed care industry toward a more efficient administration of information relative to that.

MR. FISHER: We want to find ways to ensure certain standards and try to provide better services for consumers and try to make the system work a little bit better. We want to hear from people what's going on regarding different issues such as privacy, access, the kind of systems that are being used, areas where HMOs feel there could be some guidance, perhaps areas where they think we shouldn't be interfering, that we could cause disruptions in services, try to get a snapshot and then try to come up with a set of recommendations to the director to try to move the HMO industry, try to set areas of standards, perhaps there are other areas, maybe not.

MR. DAVIES: We often overlook the other technologies. For example, digital technologies and communications, which I believe will define the way health care is experienced and how it's delivered. Maybe we can also look at what's coming over the horizon with either very targeted types of capabilities that can be made available to health plans or to employers or to individuals and get sort of a representative sense of that.

MR. FISHER: We don't want to disrupt a system that is good, we want to try to maybe see if there are ways we can have medical records that are standardized, so that if a patient goes from one HMO to another, an on-line medical record can easily be transferred to the other health plan, that kind of thing we want to try to get an assessment now. Perhaps what we'll learn from this is the best thing for us to do is to stay out and let them sort themselves out or maybe we need to provide guidance in this area or that area, something like that.

PUBLIC COMMENTS: NONE

CLOSING COMMENTS:

MR. SCHULTZ: (Referred to a handout showing legislation introduced in the 2001 legislative session, potentially impacting to the Department of Managed Health Care and the consumers that the Department serves in one way or another.) There are bills relating to provider contracting, continuity of care, dispute resolution, emergency services, coverage mandates, individual reform,

access issues, pharmacy, quality of care and a broad category of what we call miscellaneous, and there are some real key bills in miscellaneous. We are trying to articulate some of the major issues confronting the department in this legislative session. We have begun to not only analyze but provide recommendation on these to the governor's office, and also to provide technical assistance to legislators and others that have questions during the process. We're very open to getting into a dialogue about legislation as it begins to move or not move through a process. But we wanted to make sure that you're aware of the bills of interest to the department that have been produced this year and this document in a modified form, because we have updated it, will be published on our website and will be updated on an ongoing basis. Members of the public can look at where the bill is in progress in the committee and the floor at any given time in the process.

Governor Gray Davis is sponsoring a bill authored by Senator Jackie Speier and Assembly Members Hannah Beth Jackson and Howard Wayne, SB37, which will provide coverage for individuals enrolled in clinical trials, both on the HMO side as well as the disability insurer side. For example, an individual accepted into a clinical trial and diagnosed with cancer would be covered for the health care services associated with this clinical trial.

Everything is on track for July 10th Advisory Committee on Managed Health Care in Los Angeles (Note: later changed to San Francisco). We'll be having the E-Health Summit consistent with the action the committee just took and we'll also be having discussion and review of the first-year annual report that's required by the legislature, and you will have that report in advance to be able to, you know, work through a review and provide recommendations.

MR. ZINGALE: Thank you all very much for attending and for your participation. If there are no objections, we will adjourn.